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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility 11/16/09 through 11/18/09, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 47 residents. The sample size was 12 residents, which included one closed record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 248	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and/or to revise the activities care plan for 1 of 12 residents, who was self isolating (Resident #1) and failed to develop specific approaches for the 1:1 room visits for 1 of 12 residents. (Resident #2) Findings include:	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Resident #1

Resident #1 was admitted to the facility on 6/6/01 with a depressive disorder, tremors , osteoporosis and hypertension. In August 2009, the resident sustained a fracture of the knee. She was fitted with a brace for treatment of the fracture.

The presence of the brace made it difficult and uncomfortable for Resident #1 to transfer out of bed or to be comfortable sitting in a wheelchair. According to Employee #16, the resident began to limit her getting out of bed and her participation in out of room activities.

The Activities Progress Update dated 9/28/09, documented that Resident #1 preferred independent leisure pursuits and that she needed to be encouraged to attend programs. The Activity Progress Update, dated 10/5/09, and labeled a Significant Change stated."(the resident) ill (sic) agree to attend activities of interest by her next evaluation." Staff feels she will increase in social activities once she is feeling better. An undated Quarterly Narrative Assessment documented that Resident #1 had declined most all social activities due to her recent fracture. It was further documented that the resident's care plan remained appropriate and it was anticipated that she would return to social activities once she was feeling better.

The Activities Care Plan was initiated on 11/4/08, and was last reviewed on 9/28/09. The only reference to room activities was that Resident #1 enjoyed watching TV and reading in her room and that Activities would check for needs of reading materials, puzzle books, etc. There were no

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F 248	Continued From page 2 specific 1:1 room visits activities developed following her fracture with her limited mobility. The Activities Records for September and October did not document any 1:1 room visits having been made by the Activities staff. There was no evidence that her special needs for activities had been considered and/or encouraged since the time of her fracture in August. Resident #2 Resident #2 was admitted to the facility on 10/7/09, with diagnoses of dementia, depressive disorder, chronic obstructive pulmonary disease and hypertension. She was 93 years old. The resident had resided in another small skilled nursing facility for many years, where her daughter could visit daily. The Activities/Quality of Life Assessment conducted on 10/7/09, indicated that the resident had not shown any interest in attending activities, and that she enjoyed listening to music. The assessment also documented that Resident #2 would benefit from 1:1 activity visits for social stimulation. The Activities Care Plan for Resident #2 developed on 10/12/09, had an approach of providing 1:1 room visits three times a week. Other than the resident might enjoy devotion during one of the visits, there were no specifics as to what activities would be provided, offered, and encouraged to this elderly resident who had recently relocated to the facility.	F 248		
F 274	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined,	F 274		

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that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to conduct a comprehensive assessment when there had been a significant change in a resident's physical condition (Resident #4).

Findings include:

Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia, diabetes, hypertension, and gastroesophageal reflux disease.

The minimum data set (MDS) indicated the resident had moderately impaired cognitive skills and needed supervision (oversight) with eating.

On a tour of the facility on 11/16/09, the nurse conducting the tour, Employee #14, indicated that Resident #4 had been experiencing weight loss and hydration "challenges." The nurse further indicated that the resident was needing more assistance by Certified Nursing Assistants (CNAs) with eating.

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Resident #4's weight upon admission (06/04/09) was 141 lbs. The resident's weight on the most recent MDS, dated 9/6/09, was 137 lbs. The resident's last nutritional assessment was conducted on 9/17/09, when the dietitian documented the following: "p.o. (by mouth) intake is fair to poor; appetite at 60% of meals; nutr. will continue to follow." A review of the resident's record revealed weights of 129.1 lbs on 9/30/09, and 128.4 lbs on 11/11/09, representing a 6.2% weight loss over a two-month period (between 9/6/09 and 11/11/09).

The Activities of Daily Living (ADL) flow sheet, completed daily in the dining room by CNAs, indicated that the resident's ability to eat declined from the categories of "Independent (0)" and "Supervision (1)" in September to "Limited Assistance (2)" and "Extensive Assistance (3)" in October. There was no evidence in the record that this increased need in feeding assistance was care planned, or that any interventions were attempted to reverse the resident's weight loss.

Record review revealed that on 10/1/09, it was determined through laboratory blood draw that Resident #4 was suffering from dehydration and had to be admitted to the hospital to receive IV (intravenous) fluids. Upon the resident's return to the facility on 10/2/09, the resident's fluid intake was not being systematically monitored. There was no evidence in the record that another blood draw had been ordered by the physician since 10/1/09, to reassess the resident's hydration status.

A significant change reassessment, reflecting Resident #4's recent decline in weight, eating ability, and hydration status, was not conducted

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F 274	Continued From page 5 by the facility. Cross-reference Tag 325	F 274		
F 278	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure complete and accurate comprehensive assessments for 2 of 12 residents	F 278		

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(Residents # 4 and #8).

Findings include:

Resident #4

Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia with dementia, diabetes, hypertension, and gastroesophageal reflux disease.

Medication orders included Depakote 125 milligrams (mg) twice daily for, "dementia with behavior disturbances (for agitation and restlessness)."

Review of the minimum data set (MDS), dated 9/6/09, revealed that the resident's use of Depakote as a psychopharmacological medication was not recorded. The Long Term Care Supervisor, Employee #6, confirmed in an interview on 11/17/09 at 10:30 AM, that Depakote, if used as a psychoactive medication, should be included under section O.4 of the MDS.

Resident #8

Resident #8 was admitted to the facility on 9/3/09, following an acute hospital stay after sustaining a fracture of her fibula and tibia. She had additional diagnoses of Multiple Sclerosis, depression and a urinary tract infection. She was confined to a wheelchair. She was discharged home on 11/4/09.

An MDS completed on 9/15/09, and identified as an admission MDS lacked the signature of the person responsible for coordinating the assessment. Note: The signature is necessary to

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F 278	Continued From page 7 certify that the MDS had been completed. Review of the resident's MDS completed on 9/29/09, and identified as an Medicare 30 day assessment showed that there was no signature of the person coordinating the assessment. Note: A signature is necessary to certify that the MDS for Resident #8 was complete. In an interview with Employee #13 on 11/17/09, she agreed that she had not signed the aforementioned MDS's.	F 278		
F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

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Based on record review and staff interview, the facility failed to develop comprehensive and current care plans for 3 of 12 residents (Resident #2, #3 and #1).

Findings include:

Resident #2

Resident #2 was admitted to the facility on 10/7/09, with diagnoses of dementia, depressive disorder, chronic obstructive pulmonary disease and hypertension. She was 93 years old. The residence had resided in another small skilled nursing facility for many years, where her daughter could visit daily.

Review of the resident record revealed that Resident #2 had a significant problem with constipation. Her face sheet carried a diagnosis of constipation. Physicians orders included daily doses of Surfak, a stool softener, and Miralax for constipation; daily, three weeks on and one week off. Documentation in the Nurses Progress Notes for 10/18/09, indicated that the resident had 2 small bowel movements in 5 days and that a suppository was given with no results. Digital stimulation was later administered that day. Review of the bowel movement record for October 2009 revealed that Resident #2 would not have bowel movements for a minimum of three days at a time. In spite of the data supporting a problem of constipation for this elderly resident, there was no evidence of a care plan for constipation.

Resident #3

Resident #3 was admitted to the facility on

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12/12/07, with an readmission from acute care facility (hospital) on 12/26/08. Her diagnoses included diabetes with insulin coverage, hypertension, edema, depression and renal failure.

Upon return from an acute care facility on 12/26/08, Resident #3 had an indwelling Foley catheter.

Review of the care plan regarding intake and output measurement, and skin integrity R/T an indwelling catheter, revealed that the care plan had not been revised or updated since 1/24/09, in regards to catheter care. Employee #6 concurred that the care plan had not been revised since its development.

Resident #1

Resident #1 was admitted to the facility on 6/6/01, with a depressive disorder, tremors , osteoporosis and hypertension. In August 2009, the resident sustained a fracture of the knee. She was fitted with a brace for treatment of the fracture.

The presence of the brace made it difficult and uncomfortable for Resident #1 to transfer out of bed or to be comfortable sitting in a wheelchair. On 11/20/09, two months after the fracture of the knee, care plans were developed regarding falls and impaired mobility. There were very specific approaches developed in regards to proper techniques in transferring Resident #1, but there was no definition of when the brace should be utilized or for what time period.

Resident #1 had a long history of urinary tract infections (UTI's). The record contained several

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F 279	Continued From page 10 resolved care plans for UTI's. At the time of the survey, the resident had been on antibiotic therapy for a UTI since 10/23/09. There was no current care plan for a urinary tract infection. When Employee # 13, the MDS Coordinator, was interviewed on 11/16/09 at 3:30 PM, she indicated that she was not aware that the resident currently had a urinary tract infection.	F 279		
F 315	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to medically justify the use of an ongoing indwelling Foley catheter in 1 of 12 residents. (Resident #3) Findings included: Resident #3 Resident #3 was admitted to the facility on 12/12/07, with an readmission from acute care facility (hospital) on 12/26/08. Her diagnoses included diabetes with insulin coverage, hypertension, edema, depression and renal failure.	F 315		

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F 315	Continued From page 11 Upon return from an acute care facility on 12/26/08, Resident #3 had an indwelling Foley catheter. Review of the physicians progress notes did not reveal any justification as to the continued use of the catheter. On 8/13/09, a facility bowel and bladder evaluation documented that the resident was motivated toward success, was aware of bowel and bladder urges and knew where the bathroom was located. She was also noted to be able to request toileting and was not aggressive during care. Review of the care plan regarding intake and output measurement, and skin integrity R/T an indwelling catheter, revealed an entry dated 1/24/09, that stated the Foley cath was for accurate intake and output due to a fluid restriction of 1500 cc per day. An entry on 6/21/09, stated that the Foley catheter was due to strict intake and output because Resident #3 was not always compliant with her fluid restriction. On 10/15/09, a physician's order had been written discontinuing the fluid restriction. In an interview with Employee #6 on 11/17/09 at 11:15 AM, it was acknowledged that she was not aware of the removal of the fluid restriction, that she was not aware why the catheter remained in place and that the care plan had not been revised or updated since 1/24/09. Employee #6 agreed that the use of a Foley catheter did not influence the compliance with fluid restriction.	F 315		
F 325	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		

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unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on record review, policy review, and interviews, the facility failed to ensure acceptable parameters of weight were maintained for 2 of 12 residents (Residents #4, #7), that a nutritional assessment was completed for 1 of 12 residents (Resident #8), and that care plans were developed and reviewed according to facility policy for all of the residents in the sample and that the duties of the dietitian were clearly defined and followed.

Findings include:

Resident #4

Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia, diabetes, hypertension, and gastroesophageal reflux disease.

The minimum data set (MDS) indicated the resident had moderately impaired cognitive skills and needed supervision (oversight) with eating.

Resident #4's weight upon admission (6/4/09) was 141 lbs. The progress note written on 6/25/09 by the facility's consultant dietitian, Employee #10, revealed that that resident lost 6 lbs in two weeks and health shakes were ordered

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to help with weight gain.

Review of physician orders revealed that the health shakes were discontinued on 7/29/09, "due to overall weight gain." The resident's weight at this time was 146 lbs. Resident #4's weight upon admission (6/4/09) was 141 lbs. The resident's weight on the most recent MDS, dated 9/6/09, was 137 lbs. The resident's last nutritional assessment was conducted on 9/17/09, when the dietitian documented the following: "p.o. (by mouth) intake is fair to poor; appetite at 60% of meals; nutr. will continue to follow." A review of the resident's record revealed weights of 129.1 lbs on 9/30/09, and 128.4 lbs on 11/11/09, representing a 6.2% weight loss over a two-month period (between 9/6/09 and 11/11/09).

The Activities of Daily Living (ADL) flow sheet, completed by Certified Nursing Assistants (CNAs), indicated that the resident's ability to eat declined from the categories of "Independent (0)" and "Supervision (1)" in September to "Limited Assistance (2)" and "Extensive Assistance (3)" in October. The last entry added to the resident's "Nutrition" care plan by Nursing was dated 9/2/09. There was no evidence in the record that this increased need in feeding assistance was care planned.

Record review revealed that on 10/1/09, it was determined through laboratory blood draw that Resident #4 was suffering from dehydration and had to be admitted to the hospital to receive IV (intravenous) fluids. Upon the resident's return to the facility on 10/2/09, one of the physicians changed the resident's diet order to a low sodium, no added salt diet. This diet change was not

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SOUTH LYON MEDICAL CENTER	P.O. BOX 940 YERINGTON, NV 89447

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updated in the Nutrition care plan, or documented in the Nutrition notes. No care plan addressing the resident's dehydration was developed by the either the dietitian or nursing staff.

According to the facility's "Hydration" policy, dated December 2005, "When it is determined by nursing, dietary, or the dietitian that a resident does not seem to be consuming sufficient fluids, or is exhibiting signs and symptoms of dehydration, the physician will be notified....An evaluation will be done to determine, if possible, the cause of the insufficient fluid intake. Laboratory studies will be evaluated...A care plan will be written that will include fluid goals, how the intake will be monitored, and suggested interventions."

There was no evidence in the record that another blood draw had been ordered by the physician since 10/1/09, to reassess Resident #4's hydration status.

On 11/17/09 at 11:30 AM, the dietitian was interviewed by phone. The dietitian indicated that she had not conducted a nutritional assessment on Resident #4 since 9/17/09, because Nursing had not alerted her to to any weight-loss concerns. The dietitian further reported that Nursing was responsible for developing and updating care plans related to nutrition and dehydration.

The dietary supervisor and risk manager, Employee #12, was interviewed on 11/17/09 at 12:00 PM. The supervisor explained that whenever the dietitian came to the facility (twice a month), Nursing gave her a weight chart for all residents, with current, 30-day, 90-day, and

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180-day weights. The chart also included the calculated percentages of weight change for these time periods, with any significant weight loss being highlighted on the chart. A review of the chart revealed that the weight change percentage for Resident #4 was highlighted, showing that he had experienced a significant weight loss over the past 90 days.

Review of the facility's "Unintended Weight Change" policy, dated December 1999, included the following statements: "Residents shall be routinely monitored for changes in their weight that are due to unintended causes. Unintended weight changes are those changes occurring for reasons other than weight reduction diets or calorie enhanced diets designed for weight gain.....The dietitian will review weights monthly and make recommendations to the nursing staff....An evaluation will be done to determine, if possible, the cause of the weight change..A care plan may be written that will include interventions to address the weight change..."

A significant change reassessment, reflecting Resident #4's recent decline in weight, eating ability, and hydration status, was not conducted by the facility.

Cross-reference Tag 274

Resident #7

Resident #7 was admitted to the facility on 11/9/09, with diagnoses including dysphagia and osteoporosis. The resident had a gastrostomy tube and, because she was unable to consume anything by mouth due to severe aspiration, was receiving all of her nutritional needs from an

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enteral formula.

The resident's admission weight was 81.2 lbs, down from 84 lbs a week earlier at the hospital. At 62 inches, the resident's ideal body weight (IBW) was 110 lbs, and upon admission to the facility, she was already only at 73.6% of her IBW. One week later, at the time of the survey on 11/17/09, Resident #7's weight was 78.7 lbs (71.5% of IBW), representing a 3.1 % weight loss over a one week period.

Record review revealed a note in the resident's record, written by Nursing on 11/9/09, which read, "new G tube, weight loss 5# over one week, maybe related to new GTF." Review of the resident's record further indicated that Nursing had completed and faxed an initial nutritional screening form to the dietitian on 11/9/09. There was no evidence in the record that the dietitian faxed back a completed "Dietitian Assessment and Recommendation Form," as directed in the facility's "Nutritional Assessment Program" policy dated December 2008. There was also no evidence that a more in-depth "Nutritional Assessment" form was completed by the dietitian within seven days, as outlined in the same policy.

An interview was conducted with the consultant dietitian by phone on 11/18/09 at 8:40 AM. The dietitian indicated that she was in the facility on 11/12/09 but had not been alerted by Nursing for the need to assess the nutritional status of Resident #7. The dietitian further explained that she was under the assumption that since she had conducted a nutritional assessment for the resident on 11/1/09, at the hospital she did not need to complete an initial nutritional assessment when the resident was admitted to the facility on

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F 325	Continued From page 17 11/9/09. Resident #8 Resident #8 was admitted to the facility on 9/3/09, following a hospital stay due to a fracture of her fibula and tibia. She had additional diagnoses of Multiple Sclerosis, depression and a urinary tract infection. She was confined to a wheelchair. Discharge to home on 11/4/09. Two forms, the South Lyon Medical Center LTC Dietician Assessment and Recommendation form and the Nutrition Progress Note were located in the resident's chart. Neither had been filled out. A Interdisciplinary Initial Care Conference note, dated 9/15/09, indicated that Resident #8's current diet was a regular diet with thin liquids and that she required supervision with eating. The documentation further indicated that Resident #8 had a 10 pound weight loss since admission, 12 days earlier. Facility Policy, Nutritional Assessment Program, effective 12/2008, stated that the Consultant Dietician must complete the Nutritional Assessment within seven days of admission. There was no evidence that Resident #8 had been seen by the dietician at any time during her admission. During an interview with Employees #6 and #13 on 11/17/09, it was disclosed that Nursing had been directed by Administration that all nutritional care plans were to be developed by the nursing staff. There was no evidence that the developed care plans were reviewed or revisited by the dietician.	F 325		

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Review of an undated Dietary Services Contract Agreement, signed by the dietician, stated that the dietician would develop appropriate care plans to meet individual needs. The contract stipulated that she would spent 12 hours a month at the long term care unit. In a telephone interview with the dietician on 11/17/09 at 11:20 AM, she confirmed that she did not developed resident nutritional care plans, but that she reviewed the care plan after its development.

The dietician also disclosed that she was involved with resident evaluations for all new admissions, specific referrals from the physicians or nursing staff, residents with weight loss or gain and residents with skin conditions. She did not normally become involved with residents with fractures, constipation, diarrhea, abnormal laboratory values, poor fluid intake or urinary tract infections. Nursing staff confirmed that they did not fax abnormal lab values to the dietician. Nutritional progress notes stated that the dietician would monitor the intake of oral fluids, but there was no evidence that this was being done. The dietician did not assess every resident monthly, but did do quarterly assessments.

In the interview with Employee #6 and #13 on 11/17/09, it was disclosed that there was no expectation for the dietician to participate in the care of residents other than new admissions, weight problems, skin conditions or direct referrals. The nursing staff indicated that they went directly to the physicians with many dietary or dietary associated needs, like dehydration and abnormal lab values. It was not anticipated that the dietician would do annual nutritional assessments. Several of the residents had not had an annual assessment since 2007. The

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F 325	Continued From page 19 policy, Nutritional Assessment Program, indicated that the Nutritional Assessment was to be reviewed and updated by the dietician yearly or in the event of a significant change in the resident.	F 325		
F 327	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and interview, the facility failed to ensure that 1 of 12 residents (Resident #4) received a sufficient amount of fluids to prevent dehydration. Findings include: Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia, diabetes, hypertension, and gastroesophageal reflux disease. The resident's weight upon admission (06/04/09) was 141 lbs. A progress note written on 6/25/09 by the facility's consultant dietitian, Employee #10, revealed that that resident lost 6 lbs in two weeks and health shakes were ordered to help with weight gain. Review of physician orders revealed that the healthshakes were discontinued on 7/29/09, "due to overall weight gain." The resident's weight at this time was 146 lbs. The resident's weight on the most recent MDS, dated 9/6/09, was 137 lbs. The resident's last nutritional assessment was conducted on 9/17/09, when the dietitian	F 327		

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documented the following: "p.o. (by mouth) intake is fair to poor; appetite at 60% of meals; nutr. will continue to follow." A review of the record revealed that the resident's weight on 9/30/09 was 129.1 lbs, representing a 5.7% weight loss over a one-month period (between 9/6/09 and 9/30/09). There were no subsequent entries in the record by the dietitian, and there was no evidence that any interventions were attempted by the facility to reverse the resident's weight loss.

Record review revealed that on 10/1/09, it was determined through laboratory blood draw that Resident #4 was suffering from dehydration and had to be admitted to the hospital to receive IV (intravenous) fluids. Upon the resident's return to the facility on 10/2/09, one of the physicians changed the resident's diet order to a low sodium, no added salt diet. This diet change was not updated in the Nutrition care plan, or documented in the Nutrition notes. No care plan addressing the resident's dehydration was developed by the either the dietitian or nursing staff. Daily fluid intake was being recorded on meal intake sheets by Certified Nursing Assistants (CNAs) in the dining room, but fluids were not being monitored in-between meals, including at med pass and snack times.

According to the facility's "Hydration" policy, dated December 2005, "When it is determined by nursing, dietary, or the dietitian that a resident does not seem to be consuming sufficient fluids, or is exhibiting signs and symptoms of dehydration, the physician will be notified....An evaluation will be done to determine, if possible, the cause of the insufficient fluid intake. Laboratory studies will be evaluated...A care plan will be written that will include fluid goals, how the

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F 327	Continued From page 21 intake will be monitored, and suggested interventions." There was no evidence in the record that another blood draw had been ordered by the physician since 10/1/09 to reassess the resident's hydration status. On 11/17/09 at 11:30 AM, the dietitian was interviewed by phone. The dietitian indicated that she had not conducted a nutritional assessment on Resident #4 since 9/17/09, because Nursing had not alerted her to to any concerns. The dietitian further reported that Nursing was responsible for developing and updating care plans related to nutrition and dehydration.	F 327		
F 431	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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F 431	Continued From page 22 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all drugs and biologicals were labeled with an expiration date when applicable and that all drugs and biologicals were stored in locked areas and with only authorized personnel having access. Findings include: 1) During observation of the facility's medication room on 11/17/2009, an opened vial of PPD Mantoux solution was found in the refrigerator. The vial was not dated as to when it had been opened. 2) In an interview with Employee #15 on 11/17/09, she disclosed that the medication room was locked at all times and that only certain licensed staff had keys to the lock. The employee also revealed that another key to the medication room was kept in a magnetic box that was unsecured near the unsecured nursing station. This key could be obtained by anyone aware of its location.	F 431		

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F 431	Continued From page 23 3) Within the medication room were medications that had belonged to residents that had been discharged or had expired.	F 431		
F 441	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure staff followed infection-control precautions related to potentially hazardous foods. In addition, the facility failed to ensure that tuberculosis testing was administered and read according to the policies of the facility for 1 of 12 residents. (Resident #8) Findings include: During a tour of the facility on 11/16/09 at 9:45 AM, an opened container of vanilla pudding was observed on a med cart. The label on the container read, "Contains milk. Perishable. Keep refrigerated." A temperature check revealed that the pudding was 69.5 degrees Fahrenheit (F). The nurse on duty confirmed that the pudding used for med pass was not routinely kept cold while on the cart. Potentially hazardous foods	F 441		

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F 441	Continued From page 24 must be kept at a temperature of 41 degrees F or below to prevent the rapid growth of pathogenic microorganisms. Resident #8 Resident #8 was admitted to the facility on 9/3/09, following a hospital stay due to a fracture of her fibula and tibia. She had additional diagnoses of Multiple Sclerosis, depression and a urinary tract infection. She was confined to a wheelchair. She was discharged home on 11/4/09. The resident's Communicable Disease Reporting record indicated that on 9/4/09, the PPD Mantoux was administered on 9/4/09. The form had no documentation of the test having been read. Review of Medication Administration Record (MAR) confirmed that Resident #8 had been administered the PPD Mantoux on 9/4/09. The MAR also did not show evidence that the test was ever read. However on 9/10/09, the second step of the PPD Mantoux was administered to Resident #8. Facility policy stated that the first step PPD would be read in 48-72 hours and that only then if negative would a second step be administered.	F 441		